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NOT TO BE PUBLISHED IN OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SIXTH APPELLATE DISTRICT

SARAH NICOLE VREELAND, Plaintiff and Appellant, v. ELIZABETH SWENSON, et al., Defendants and Respondents.	H045222 (Santa Clara County Super. Ct. No. 2015-1-CV-283604)

Plaintiff Sarah Nicole Vreeland appeals from a judgment entered after the superior court granted summary judgment to defendants Elizabeth Swenson, M.D. and the Palo Alto Foundation Medical Group in plaintiff's action for medical negligence. Plaintiff contends that the court erred in determining that there was no triable issue of fact on the element of causation of plaintiff's injuries. We agree and therefore must reverse the judgment.

Background[1]

When plaintiff was two months old, she received a ventriculoperitoneal (VP) shunt to control obstructive hydrocephalus resulting from a brain tumor. The shunt was revised

[1] We summarize the factual history of this case without the benefit of assistance from defendants, who refer us only to their memorandum of points and authorities below. That document itself contains inaccurate statements of fact, which only illustrates why it is necessary to provide *evidence*, not assertions, to the Court of Appeal. It should require no reminder that factual statements in an appellate brief must be supported by appropriate reference to the page in the record where that fact may be found. (Cal. Rules of Court, rule 8.204(a)(1)(C).) "It is not the duty of a reviewing court to search the record for

in 1993 when plaintiff was three years old and again in 2008 when she was 19. According to plaintiff, she underwent additional surgical procedures, such as a knee arthroscopy in 2010 and a 2012 cholecystectomy; during these procedures she received prophylactic antibiotics "[d]ue to the increased risk of infection" posed by the shunt in her body.[2] According to defendants, by August 2014 she had not experienced any infections related to the shunt.[3]

On August 1, 2014, at the age of 24, plaintiff underwent gynecological surgery to remove a suspected endometrial polyp. The procedure, performed by defendant Swenson at the Surgecenter of Palo Alto, consisted of a hysteroscopy, polypectomy, and dilation and curettage. It is undisputed that no prophylactic antibiotics were administered before or during the procedure. The parties did dispute whether the decision not to give antibiotics to a patient with a foreign body such as a shunt met the standard of care of reasonably careful physicians.

Within a week of the surgery, plaintiff began to experience symptoms of infection surrounding the distal end of the shunt. On August 13, 2014, she appeared at the emergency department at Stanford Hospital with complaints of "sharp, constant, mid-sternal chest pain with overlying erythema." A CT scan performed there showed "stranding surrounding Plaintiff's shunt tubing from the sternomanubrial joint to the rectus muscle." Providers at Stanford determined that plaintiff "appeared to have cellulitis overlying her thoracic shunt catheter with imaging concerning for infection of distal tubing." On August 15, 2014, she underwent a shunt externalization, followed later

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evidence on a point raised by a party whose brief makes no reference to the pages where the evidence can be found." (*ComputerXpress, Inc. v. Jackson* (2001) 93 Cal.App.4th 993, 1011.) We will disregard the entire statement of facts in defendants' brief.

[2] Each party asserted facts relating to prior medical procedures in their separate statements, while the other party objected on hearsay and other grounds.

[3] The evidence on this point, which plaintiff disputed, is unclear. The medical records at Stanford Hospital contain reports of "[I]nfection along shunt 12/18/2008."

that month by additional surgical procedures that were "designed to craft an alternative to Plaintiff's existing infected VP shunt." Defendants admitted these facts, but they insisted that plaintiff "was never diagnosed with an infection."

On July 28, 2015, plaintiff filed her complaint for medical negligence.[4] Defendants answered the complaint and moved for summary judgment, or alternatively, summary adjudication. After considering expert declarations and medical records proffered by each party, the superior court granted summary judgment to defendants, finding no triable issue of material fact as to the cause of plaintiff's injuries. From the ensuing judgment in defendants' favor, plaintiff brought this timely appeal.

Discussion

1. Principles of Review

"Summary judgment is appropriate when all of the papers submitted show there is no triable issue of material fact and the moving party is entitled to a judgment as a matter of law. (Code Civ. Proc., § 437c, subd. (c).)" (*Wright v. County of San Mateo* (2019) 33 Cal.App.5th 931, 936-937.) A triable issue of material fact exists "if, and only if, the evidence would allow a reasonable trier of fact to find the underlying fact in favor of the party opposing the motion in accordance with the applicable standard of proof." (*Aguilar v. Atlantic Richfield Co*. (2001) 25 Cal.4th 826, 850 (*Aguilar*).) On appeal, we review the grant of summary judgment de novo, considering all the evidence set forth in the moving and opposition papers, except evidence to which objections were made and properly sustained by the trial court, and all inferences reasonably drawn from the evidence. (Code Civ. Proc., § 437c, subd. (c); see *Regents of University of California v. Superior Court* (2018) 4 Cal.5th 607, 618.) We view the evidence in the light most favorable to

[4] Plaintiff originally named the Palo Alto Medical Foundation and Palo Medical Foundation for Health Care, Research and Education, but those entities were replaced by the Palo Alto Foundation Medical Group by stipulation of the parties.]

the party opposing summary judgment, liberally construing the opposing party's submissions and resolving all doubts concerning the evidence in favor of the opposing party. (*Wilson v. 21st Century Ins. Co.* (2007) 42 Cal.4th 713, 717; *Aguilar*, *supra*, at p. 843.)

In undertaking this review, we apply the same analysis that was required of the trial court: " 'First, we identify the issues framed by the pleadings since it is these allegations to which the motion must respond . . . . [¶] Secondly, we determine whether the moving party's showing has established facts [that] negate the opponent's claim and justify a judgment in movant's favor . . . [¶] When a summary judgment motion prima facie justifies a judgment, the third and final step is to determine whether the opposition demonstrates the existence of a triable, material factual issue.' " (*Zuckerman v. Pacific Savings Bank* (1986) 187 Cal.App.3d 1394, 1400-1401, quoting *AARTS Productions, Inc. v. Crocker National Bank* (1986) 179 Cal.App.3d 1061, 1064-1065 (*AARTS*).)

2. Plaintiff's Complaint

"Because summary judgment is defined by the material allegations in the pleadings, we first look to the pleadings to identify the elements of the causes of action for which relief is sought." (*Baptist v. Robinson* (2006) 143 Cal.App.4th 151, 159; *Jones v. Wachovia Bank* (2014) 230 Cal.App.4th 935, 945 (*Jones*), quoting *AARTS*, *supra*, 179 Cal.App.3d at p. 1064.) In her complaint she alleged that defendants "negligently managed, treated, cared for and performed surgery on plaintiff" without administering pre- or post-surgery prophylactic antibiotics to prevent infection of her brain shunt. As a result, she suffered "severe infections, pain, injuries, [and] disability and has had to under go [*sic*] extensive medical interventions, therapies and treatment," as well as "severe emotional distress."

As the party with the ultimate burden at trial, plaintiff would be required to establish medical negligence by proving "(1) a duty to use such skill, prudence, and diligence as other members of the profession commonly possess and exercise; (2) a

breach of the duty; (3) a proximate causal connection between the negligent conduct and the injury; and (4) resulting loss or damage." (*Johnson v. Superior Court* (2006) 143 Cal.App.4th 297, 305.)

With respect to the first element, the standard of care for medical professionals requires " ' "that a physician or surgeon have the degree of learning and skill ordinarily possessed by practitioners of the medical profession in the same locality and that he [or she] exercise *ordinary care* in applying such learning and skill to the treatment of [the] patient." ' [Citation.]" (*Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 998; see also *Brown v. Colm* (1974) 11 Cal.3d 639, 642-643 (*Brown*) ["a doctor is required to apply that degree of skill, knowledge and care ordinarily exercised by other members of his profession under similar circumstances"].) "Proof of this standard is ordinarily provided by another physician, and if a witness has disclosed sufficient knowledge of the subject to entitle his opinion to go to the jury, the question of the degree of his knowledge goes to the weight of his testimony rather than to its admissibility." (*Brown*, *supra*, at p. 643; *In re Roberto C.* (2012) 209 Cal.App.4th 1241, 1249.) Thus, the standard of care can ordinarily be proved only by the experts' testimony, " 'unless the conduct required by the particular circumstances is within the common knowledge of the layman.' [Citations.]" (*Landeros v. Flood* (1976) 17 Cal.3d 399, 410.)

Proof of causation may also require expert testimony "[w]here the complexity of the causation issue is beyond common experience." (*Garbell v. Conejo Hardwoods, Inc.* (2011) 193 Cal.App.4th 1563, 1569; accord, *Webster v. Claremont Yoga* (2018) 26 Cal.App. 5th 284, 290.) In a summary judgment proceeding, however, the expert's opinions may be rejected if they are conclusory, speculative, without foundation, or stated without sufficient certainty. (*Sanchez v. Kern Emergency Medical Transportation Corp.* (2017) 8 Cal.App.5th 146, 155-156.) "Moreover, an expert's opinion rendered without a reasoned explanation of why the underlying facts lead to the ultimate

conclusion has no evidentiary value because an expert opinion is worth no more than the reasons and facts on which it is based." (*Bushling v. Fremont Medical Center* (2004) 117 Cal.App.4th 493, 510; accord, *Alexander v. Scripps Memorial Hospital La Jolla* (2018) 23 Cal.App.5th 206, 225.)

3. Defendants' Showing

As the moving party, defendants have the initial burden of showing that plaintiff's action or cause of action has no merit—that is, "that one or more elements of the cause of action, even if not separately pleaded, cannot be established, or that there is a complete defense to that cause of action." (Code Civ. Proc., § 437c, subds. (*o*)(1), (p)(2); see *Jones, supra,* 230 Cal.App.4th at p. 945.) We must therefore determine whether defendants have "conclusively negated a necessary element of the plaintiff's case, or [have] demonstrated that under no hypothesis is there a material issue of fact that requires the process of trial, such that [defendants are] entitled to judgment as a matter of law." (*Guz v. Bechtel National. Inc.* (2000) 24 Cal.4th 317, 334; *Daly v. Yessne* (2005) 131 Cal.App.4th 52, 58.) If defendants failed to make this initial showing, it is unnecessary to examine plaintiff's opposing evidence and we must conclude that the motion should have been denied. However, if the moving papers "make a prima facie showing that justifies a judgment in [defendants'] favor, the burden of production shifts to the plaintiff to make a prima facie showing of the existence of a triable issue of material fact." (*Jones, supra,* at p. 945; *Professional Collection Consultants v. Lauron* (2017) 8 Cal.App.5th 958, 965 (*Lauron*).)

A defendant "may, but need not, present evidence that conclusively negates an element of the plaintiff's cause of action. The defendant may also present evidence that the plaintiff does not possess, and cannot reasonably obtain, needed evidence—as through admissions by the plaintiff following extensive discovery to the effect that he [or she] has discovered nothing." (*Aguilar, supra,* 25 Cal.4th at p. 855; *Lauron, supra,* 8 Cal.App.5th at p. 965.) However, the defendant may not "simply point out that the

plaintiff does not possess, and cannot reasonably obtain, needed evidence," but "*must* indeed present [']evidence.' " (*Aguilar*, *supra*, at pp. 854, 855; *Lauron*, *supra*, at p. 965.)

If the defendant fails to make this initial showing, it is unnecessary to examine the plaintiff's opposing evidence and the motion must be denied. However, "[i]f a defendant's moving papers make a prima facie showing that justifies a judgment in its favor, the burden of production shifts to the plaintiff to make a prima facie showing of the existence of a triable issue of material fact." (*Jones*, *supra*, 230 Cal.App.4th at p. 945; *Lauron*, *supra*, 8 Cal.App.5th at p. 965.)

Defendants' motion for summary judgment addressed the first two elements of negligence: They asserted that (1) Dr. Swenson's decision not to use prophylactic antibiotics in the procedure was within the standard of care of reasonably careful gynecologists and (2) that decision had not caused an infection of plaintiff's VP shunt. Defendants offered the declarations of Richard A. Jacobs, M.D., Ph.D., and Charlene Reimnitz, M.D. Dr. Jacobs, an emeritus clinical professor of medicine and clinical pharmacy, had reviewed the medical records from the Palo Alto Medical Foundation, Stanford University Medical Center, and the Surgecenter of Palo Alto. He quoted a practice bulletin for hysteroscopy procedures as stating that " '[r]outine antibiotic prophylaxis is not recommended for the general patient population undergoing hysteroscopic surgery.' " He therefore determined that Dr. Swenson had met the standard of care in performing this procedure on August 1, 2014. Dr. Jacob expressed the further opinion that plaintiff "cannot establish within a reasonable degree of medical probability" that the decision not to use prophylactic antibiotics that day caused an infection of plaintiff's VP shunt. He noted that uterine bacteria are not the kind of organisms that usually cause shunt infections. Dr. Jacob concluded that the standard of care did not require antibiotic prophylaxis for the procedure performed by Dr. Swenson and that plaintiff was not at risk for infection that day, having experienced no shunt-related infections previously.

Dr. Jacob acknowledged that when plaintiff appeared at Stanford's emergency department on August 13, 2014 with "mid sternal chest pain and erythema (redness)," the clinical impression was cellulitis. However, the lab cultures performed at Stanford showed "no growth," and therefore no specific bacteria were identified as the cause of "any presumed infection or cellulitis." Dr. Jacob further noted that the VP shunt was removed on August 27, 2014, and by October 9 the neurosurgeon stated that the cellulitis had "resolved and all her CSF cultures remained negative."[5] The witness concluded that it was "impossible to say that the procedure performed on August 1 resulted in the subsequent shunt infection."

Dr. Reimnitz, a specialist in obstetrics and gynecology, reached the same conclusion after reviewing the medical records. She agreed that the standard of care did not require the administration of antibiotic prophylaxis for the gynecologic procedure performed on plaintiff; plaintiff had not experienced any prior episode of infection related to the shunt, and the procedure itself would not have placed plaintiff at high risk for infection.

The superior court found the declarations of these experts to be sufficient as to both Dr. Swenson's compliance with the standard of care and the lack of causation. It further determined, however, that plaintiff's responsive evidence had demonstrated "the existence of a triable issue of material fact as to whether Defendants met the applicable standard of care with regards [*sic*] to the August 1, 2014 procedure." On that point defendants do not return to the position they asserted below; they no longer argue that Dr. Swenson's decision not to administer prophylactic antibiotics met the applicable standard of care. Consequently, the only issue on appeal is the viability of plaintiff's allegations regarding the element of causation.

[5] The "CSF" reference is presumably to cerebrospinal fluid.

We agree with the superior court that Drs. Jacob and Reimnitz provided reasoned explanations of their opinions sufficient to meet defendants' initial burden of production with respect to the element of causation. The burden therefore shifted to plaintiff to submit expert declarations demonstrating the existence of a material fact on this issue.

4. Plaintiff's Showing

Plaintiffs' experts, Grace D. Hasid, M.D., and Dennis M. Israelski, M.D., had also reviewed plaintiff's medical records, but they reached a different conclusion from those of Drs. Jacob and Reimnitz. In her declaration Dr. Hasid highlighted the notes on plaintiff's emergency visit on August 13, 2014, as reporting apparent "cellulitis overlying her thoracic shunt catheter with imaging concerning for infection of distal tubing." Dr. Hasid referred to the diagnosis as a MRSA infection which caused a significant loss of brain function, and she described the ensuing treatment as involving "weeks of hospitalization and the surgical revision of [plaintiff's] shunt to save her life." The ensuing medical intervention included an August 15 "shunt externalization," the insertion on August 17 of a PICC line to administer antibiotics, and further surgeries on August 27 and 29 "to craft an alternative to the infected shunt."

In Dr. Hasid's view, plaintiff "was at risk of developing a shunt infection as a result of the August 1, 2014 abdominal surgery." In contrast to the opinion of Drs. Jacob and Reimnitz, Dr. Hasid stated that "[i]t is the community standard of care to provide antibiotic prophylaxis for patients with indwelling foreign bodies, such as a VP shunt." She concluded: "It is my medical opinion that the use of pre-operative and intra-operative antibiotics should have been utilized in this case, and would have prevented the MRSA infection surrounding [plaintiff's] shunt. A medical professional should use caution in this type of complicated case and should be sure to individualize plans, including the administration of prophylactic antibiotics, so as to ensure the best possible outcome. It has been clearly established in medical literature that the administration of prophylactic antibiotics in such circumstances serves to prevent the occurrence of

infections." By failing to use such precautions, Dr. Swenson "failed to meet the applicable standard of care." Dr. Hasid expressed the belief "to a reasonable degree of medical probability" that had plaintiff been given a prophylactic antibiotic prior to the procedure performed by Dr. Swenson, "the infection surrounding [plaintiff's] VP shunt never would have occurred."

Dr. Israelski, a board-certified specialist in internal medicine and infectious diseases, reached a similar conclusion. He characterized the apparent cellulitis overlying the shunt catheter marked by the CT indications of stranding surrounding the distal tubing as a "life-threatening infection," which resulted in "significant cognitive impairment" that required plaintiff to withdraw from her first year of law school. Dr. Israelski believed, "to a reasonable degree of medical probability," that if plaintiff had been given a prophylactic antibiotic before and during the procedure, "the infection surrounding [plaintiff's] VP shunt never would have occurred."

Supported by the declarations of Drs. Hasid and Israelski, plaintiff's separate statement of undisputed facts included the Stanford physicians' diagnosis of cellulitis and "imaging concerning for infection of distal tubing." Although defendants disputed the existence of an infection, they did not contest the descriptions of the treatment with antibiotics through the PICC line. Yet the superior court rejected the expert opinions of Drs. Hasid and Israelski based on its *own* review of plaintiff's medical records, which led it to conclude that "there is nothing in the medical records to suggest that Plaintiff had a MRSA infection, *or any other bacterial infection* as a result of the August 1, 2014 procedure." (Italics added.) While the court accepted defendants' references to "blood cultures" on unspecified dates, it discredited the concern of the emergency department personnel that infection existed one week after the procedure. The court cited a MRSA screen indicating that no MRSA was isolated on August 15, 2014 and a CSF culture showing "NO ORGANISMS SEEN" and "NO GROWTH."

The lab reports, however, do not explain what medical inferences can be drawn from those few words summarizing each result. The first cited report indicated only that this one pathogen, MRSA, was not found on a specific screen for MRSA. The culture specific to the cerebrospinal fluid on August 24, 2014 indicated that no organisms were found in that specimen, but it did not explain the indications of infection and administration of antibiotics noted by Stanford physicians following plaintiff's August 13 hospital admission.[6] On August 14 Drs. Gomez and Blackburn from the Infectious Disease department discussed two possible approaches to the "subcutaneous infection" revealed by the CT: "Shunt removal and reimplantation," which would "require IV antibiotics for 7-10 days post-Op"; or retain the current VP shunt "and treat with IV antibiotics for at least 2 weeks," followed by oral antibiotics. Pending the family's choice between the two options, the physicians recommended "continu[ing] Vancomycin IV at current dose." The records over the days following plaintiff's admission to Stanford contain administration of many substances; to the extent that those medications included antibiotics, it is not for us to say whether they could have inhibited the growth of bacteria present at admission.

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[6] The records of plaintiff's hospital stay after being admitted on August 13, 2014 include the emergency physician's expression of "concern for line infection" and the following plan: "will start abx and admit to NSG for possible externalization." The day after admission, Dr. Li, the attending physician on August 14, suggested the "possibility of treating infections with antibiotics alone instead of externalization of shunt." On August 17 another note documents "PICC placed given likelihood of IV abx if shunt needs to be replaced." Scheduled medications from August 16 through August 26 included vancomycin through the time of plaintiff's anticipated surgery. For two days before plaintiff's scheduled surgery on August 27, progress notes indicate that plaintiff "will stay on vanco till the surgery day." On August 25 Dr. Blackburn suggested, "Reasonable to cont vancomycin IV through the time of planned surgery (Wed of this week), as per primary team. Probably would not treat for more than 2 weeks total, since the infected source was removed." Finally, notes on August 27, 2014 from primary neurosurgeon Michael Edwards, M.D., include his preoperative *and* his postoperative diagnosis of "Infected right ventriculoperitoneal shunt secondary to abdominal procedure producing peritoneal catheter infection."

The superior court was not qualified to evaluate the meaning and significance of these lab results, hypotheses, recommendations, and conclusions, which contained technical terms and abbreviations of terminology (e.g., "abx") that required expert interpretation consistent with the nature and timing of the cultures performed and analyzed. The court therefore exceeded its role in this summary judgment proceeding by drawing factual conclusions based on selected excerpts from plaintiff's extensive medical records. "Like breach of duty, causation is ordinarily a question for the trier of fact which cannot be resolved by summary judgment. The issue of causation may be decided as a question of law only if, under undisputed facts, there is no room for a reasonable difference of opinion." (*Nichols v. Keller* (1993) 15 Cal.App.4th 1672, 1687; accord, *Vasquez v. Residential Investments, Inc*. (2004) 118 Cal.App.4th 269, 288.)

We cannot say that there was "no room for a reasonable difference of opinion" here. To the contrary, our de novo review of the parties' evidence convinces us that there is indeed a triable issue of fact on the material issue of whether the decision not to administer prophylactic antibiotics for the August 1, 2014 procedure caused plaintiff to suffer an infection of her VP shunt. Indeed, contrary to defendants' insistence that plaintiff "was never diagnosed with an infection," the medical record is replete with references to such a diagnosis. (See fn. 6, *ante*.) Whether that reported infection could have been avoided by the administration of prophylactic antibiotics remains a question to be answered by the trier of fact.

We express no opinion about plaintiff's ultimate ability to prove her case should it go to trial. Defendants might discredit her experts on cross-examination by eliciting interpretations of specific entries in the medical records or by querying the experts on scientific findings relevant to patients in similar circumstances. However, even if a plaintiff's prospects of recovery appear to be slight, "on a motion for summary judgment we are bound by the statute to distinguish between a case [that] is simply weak and a case [that] 'cannot be established.' " (*Hagen v. Hickenbottom* (1995) 41 Cal.App.4th 168,

188, superseded by statute on other grounds as stated in *Rice v. Clark* (2002) 28 Cal.4th 89, 96-98.) Accordingly, we must remand plaintiff's case to the superior court for trial or other disposition.

Disposition

The judgment is reversed.

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ELIA, J.

WE CONCUR:

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GREENWOOD, P. J.

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PREMO, J.

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